Visiting Nurses Association of Central Illinois *and* Illinois Nurses Association, Petitioner. Case 33–RC–4087

July 25, 1997

DECISION ON REVIEW AND ORDER

BY CHAIRMAN GOULD AND MEMBERS FOX AND HIGGINS

On November 20, 1996, the National Labor Relations Board granted the Employer's request for review of the Regional Director's Decision and Direction of Election (pertinent portions are attached as an appendix).[1] Having carefully reviewed the entire record, we affirm the Regional Director's finding that the petitioned-for unit of the Employer's registered nurses (RNs) constitutes an appropriate unit.[2] In doing so, we find it unnecessary to determine whether the Regional Director was correct in finding that the Employer (VNA) and Memorial Medical Center (MMC) are not a single employer.[3] Even if the Employer and MMC are a single employer, we find, in agreement with the Regional Director, that the petitioned-for single-facility healthcare unit is presumptively appropriate; that the Employer has failed to meet its burden to overcome the presumption; and that, therefore, the petitioned-for, single-location unit of the Employer's RNs is appropriate for bargaining. See *Manor Healthcare Corp*., 285 NLRB 224 (1987).

At the outset, we find that the Employer's building constitutes ''a single facility'' and we apply the presumption that a single-facility healthcare unit is appropriate. Although the nature of a visiting nurse business requires it to provide services at patients' homes rather than at a central location, the Employer's facility is the workplace of the Employer's management and triage RNs. The Employer's other RNs also come to the facility, often on a daily basis, to check on assignments and to do paperwork, and the Employer coordinates nurse scheduling from that facility.

We also find that the day-to-day interests of the RNs at the Employer's facility have not been merged with those of the RNs at MMC and that the petitioned-for single facility retains its separate identity. MMC is an acute care hospital. The Employer's services—home health and hospice care—are distinct from those provided by MMC. The Employer operates with its own staff and its own patients. Although most of its patient referrals are from MMC, 25 to 30 percent of its patients are referred from other sources. The Employer's RNs have separate and distinct work functions, skills, and working conditions (work setting, dress, daily routine, and different hours) and perform more general functions rather than the specialized functions performed at MMC.

We recognize that MMC's personnel department provides personnel services for the Employer, which does not have its own department. Significantly, however, day-to-day labor relations are controlled by the Employer through its own executive director, Barbara Sullivan,[4] and its other managers. MMC's personnel department screens job applicants, but the Employer interviews them and makes its own hiring decisions. MMC sets salary ranges, but the Employer's own managers make salary changes within those ranges. MMC's personnel department ensures only that the correct process is used. Similarly, the Employer's managers issue the employee evaluations that result in merit increases; MMC only checks for consistency with the ratings systems. MMC is experimenting with a different appraisal system for a number of its RNs, a system which the Employer does not use. First- and second-level grievances are handled by the Employer. Although the Employer grants its employees many of the same benefits received by MMC employees, certain significant additional benefits have been granted by the Employer—use of sick time; weekend differentials; vacation carryover; and part-time holiday time. Sullivan sets hours, which differ from those at MMC, and decides promotions. The Employer may seek advice from MMC with regard to discipline, but the Employer makes the discipline decisions and Sullivan's daily conferral with the MMC personnel department is simply to obtain advice rather than to obtain approval. Sullivan has never been overruled by MMC with respect to her personnel decisions. Thus, the evidence establishes that the Employer controls its own labor relations.

The Employer's RNs are separately supervised by the Employer's director and managers. RNs who ''float'' from MMC to the Employer (i.e., ''moonlight'' or work on a volunteer basis during their off-hours) work under the Employer's supervision while at the Employer. Although the Employer designates 17 RNs as ''shared services'' RNs, whom the Employer apparently defines as RNs who work for both the Employer and MMC,[5] all but 1 spend all or almost all of their time performing work for MMC and work under MMC supervision. The one exception is an employee who is supervised by the Employer, is based at the

[1] In its request for review, the Employer contended, inter alia, that the other professional employees at the Employer's home health care facility must be included in the unit. On December 5, 1996, the Board approved the Employer's November 27, 1996 request to withdraw that portion of its request for review.

[2] There are 67 RNs in the unit found appropriate by the Regional Director.

[3] As used here, the term ''Employer'' refers to VNA.

[4] Although MMC pays Sullivan's salary, there is no evidence that this fact in any way limits her or the Employer's discretion in determining and effectuating its labor relations policies.

[5] These include seven clinical nurse specialists, one pain management nurse, and nine home health clinicians.

Employer's facility, and is classified as the Employer's employee. Further, although the Employer claims that the 13 ''monitor RNs'' monitor the Employer's patients while working at the MMC facility under MMC supervision, the record fails to show the portion of their time they spend in doing so.

There is limited employee interchange among nonsupervisory employees of the Employer and MMC.[6] The Employer uses a private agency to fill most of its need for supplemental nurses. No more than 25 of over 500 RNs have ''floated'' from MMC to the Employer over a 1-year period—(July 1995 to June 1996). Furthermore, during that period, all but a few averaged fewer than 2 hours a month working at the Employer.

There is little contact between the Employer's and MMC's RNs. The Employer's RNs have no reason to enter the MMC building. Their contact with MMC's RNs on patient discharge is no greater than that with RNs at other referring hospitals. MMC's floaters do not work with the Employer's RNs. Only 2 or 3 of MMC's 17 shared-services RNs have regular job-related contact with the Employer's RNs.

Thus, we find that the Employer retains control of daily labor relations, that there is only minimal interchange and contact between employees of the Employer and MMC, and that the employees are separately supervised. These factors strongly favor the single-facility unit that the Regional Director found appropriate. There is, to be sure, some evidence favoring a multifacility unit: i.e., the close proximity of the Employer and MMC; the fact that a substantial percentage of the Employer's nursing staff were permanent transfers from MMC to the Employer; there are some shared nonmedical services (groundskeeping, housekeeping, food, after-hours switchboard); there is some degree of functional integration through patient referrals and through shared services of RNs and other professionals. But these factors are insufficient to destroy the separate identity of the different facilities in light of our findings above. The Employer, therefore, has failed to rebut the presumptive appropriateness of the Employer's single-facility RN unit. See *O'Brien Memorial*, 308 NLRB 553 (1992) (single-facility unit appropriate despite some administrative centralization where there was separate day-to-day control of labor relations, little interchange or contact, and little functional integration) and *Passavant Retirement & Health Center*, 313 NLRB 1216, 1218 (1994) (single-facility presumption unrebutted despite geographic proximity and some integration of functions where there was separate supervision, an absence of interchange and contact, and different skills).

The cases cited by the Employer in support of a multifacility unit are distinguishable. In *Lutheran Welfare Services of Northeastern Pennsylvania*, 319 NLRB 886 (1995), the Board found that the single-facility presumption had been rebutted because, unlike here, the employer performed the same work at two proximate facilities (nursing homes 100–200 feet apart), there was significant functional integration and interchange involving most of the classifications petitioned for, and several employees floated between facilities as part of their regular jobs. In *Presbyterian/St. Luke's Medical Center*, 289 NLRB 249 (1988), the Board relied on, inter alia, the integration of patient care among facilities, the frequency of transfers between facilities, and the frequency of contact among employees of different facilities in finding the single-facility presumption rebutted and a systemwide unit appropriate. Furthermore, in *Presbyterian/St. Luke's*, supra at 251 fn. 5, the Board did not apply its single-facility presumption, having accepted on remand as the law of the case the Tenth Circuit's conclusion that the presumption was unwarranted. See *Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450, 455 (1981). In *West Jersey Health Club*, 293 NLRB 749 (1989), the Board found a systemwide unit appropriate, relying on the routine rotation of unit employees between divisions, regular supervision of unit employees in some instances by managers with systemwide responsibilities, and systemwide posting. Further, patient care support services, e.g., equipment and meals, were integrated among the facilities, resulting in the possibility that the provision of patient care would be adversely affected, if single-location units were deemed appropriate. In *Child's Hospital*, 307 NLRB 90 (1992), the Board found that three operations (a hospital, nursing home, and service center) constituted a single facility where the operations were contiguous (in a single building), there was considerable integration of operations (including admissions and lab work), and a high degree of contact.

Thus, in those cases, the Board found that the single-facility presumption had been rebutted based on, inter alia, factors that strongly militated in favor of a multisite unit, i.e., regular interchange of employees, common supervision, more complete and substantial integration of patient care facilities. We have found that these factors are not present here. Accordingly, we agree with the Regional Director that the petitioned-for single-location RN unit is appropriate.

ORDER

The Regional Director's Decision and Direction of Election is affirmed, and the case is remanded for further appropriate action.

[6] The Regional Director's finding of substantial interchange clearly refers to permanent transfers rather than temporary interchange.

APPENDIX

DECISION AND DIRECTION OF ELECTION

The Scope of the Unit—Background

The Employer (VNA) is a nonprofit corporation having its own Articles of Incorporation and bylaws describing its corporate purposes and operational authority. Prior to 1984, VNA operated as an independent, nonprofit entity. In 1984, VNA was acquired by and became affiliated with Memorial Medical Center Health Care System (MMC System), Memorial Health System's predecessor. MMC System assumed approximately $20,000 of VNA's debt, and VNA's board of directors agreed to make MMC System its sole corporate member and owner.

After the above-described acquisition, VNA retained its name and remained a separate corporation. Shortly thereafter, VNA moved onto the ''campus'' of MMC System. The campus will be described below. In or about 1993, MMC System was renamed Memorial Health System (MHS). MHS continues to be the owner and the sole corporate member of the VNA. As the corporate member of the VNA, MHS appoints the VNA board of directors and may remove them at its discretion.

MHS is a nonprofit Illinois corporation. It is a holding Company which currently holds 12 active affiliated corporations with a total of more than 4000 employees located in the central part of the State of Illinois and directly employs approximately 75 employees. It administers its health care system, but does not directly provide health services.

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MHS owns a group of connected large parcels of real estate and buildings in Springfield, Illinois. On the central and largest parcel is the MMC complex of hospital buildings. The complex is semisurrounded by parking facilities owned by MHS and utilized by MMC. Southern Illinois University Medical School is located just west of the MMC complex. The State of Illinois owns most of this property and leases the rest from MHS. The VNA building is located west of the Southern Illinois University Medical School (SIUMS) complex. It is a separate building with its own parking facilities and is not connected physically with any MMC or SIUMS facility. The VNA building is approximately 2-1/2 blocks west of the MMC area complex with the SIUMS complex in between. As indicated, Memorial Child Care (MCC), Alternative Care Services (ACS), and Mental Health Centers of Central Illinois (MHCI) also have their facilities in this general area which I have referred to as the MHS campus. MHS' executive offices are located in the MMC complex. MHS also owns the real property housing the Lincoln and the St. Vincent Hospitals in their respective communities.

The VNA

VNA's principle purpose is to supply quality health care to patients in their homes. VNA's three basic programs are the home health program, the continuous care program, and the hospice program. The home health program deals with Medicare and Medicaid insured patients who require medical care in their homes. The continuous care program provides nursing services as needed but it is not reimbursed by Medicare and Medicaid. This program is often involved with the assistance and care of patients who either because of age or other problems cannot take care of themselves to the extent that they need care in their homes. The hospice program involves the providing of assistance and support of patients who are terminally ill.

Generally, a ''primary nurse'' coordinates and plans the care of the home patient including the various services necessary to accomplish that care such as physical therapy, occupational therapy, or social work. As in a hospital setting, the registered nurse plans and handles all the skilled nursing functions including medications, intravenous feeding, cardiac problems, and psychiatric care. It appears that the essential differences in the work of registered nurses involved in the practice of home health as opposed to hospital-based registered nurses is the travel involved, the importance of the home environment to the patients, and the educational function that is provided to the patients and family members.

As indicated above, MHS owns the VNA building which still has a mortgage pending on it. VNA leases the building from MHS and pays rent to MHS at fair market value. VNA shares or utilizes certain building services from MMC. Building services such as security, engineering, groundskeeping, and housekeeping are performed by MMC personnel and the cost is billed back to VNA by MMC.

Barbara Sullivan is the executive director of the VNA. Sullivan is in charge of the day-to-day operations of the VNA. She is on the payroll of MHS and VNA reimburses MHS for her salary. She reports to Ed Curtis. Curtis is the executive vice president and the chief operating officer of MHS. Sullivan also reports to the board of directors of VNA and conducts the operations of VNA in accordance with VNA bylaws. As indicated above, MHS, as the sole corporate member, appoints the VNA board of directors who are authorized by the VNA bylaws to oversee the management and operation of the VNA.

Under VNA bylaws, MHS must approve annual and long term and operational budgets of the VNA. Sullivan and Curtis have worked together to prepare annual and long term budgets. The VNA board considers the proposal, may amend it, and sends it to the MHS board for final approval. At the time of the hearing, Curtis was in the process of having David Sniff, a senior vice president for system integration at MHS, placed on the VNA board and making him an intermediary between Sullivan and Curtis. Apparently, Sullivan will report to Sniff and Sniff will report to Curtis. This change is intended to relieve Curtis of some of his responsibilities which have increased with the growth of MHS and will not diminish Sullivan's authority relative to the day-to-day operations of the VNA.

Sullivan has the authority to and does enter into contracts for items such as supplies, equipment, and outside help. She has and exercises the authority to set the hours of work, the rates of pay, and terms and conditions of employment of VNA employees. However, the VNA board does not have a personnel committee and VNA does not have a personnel department. Human resource and the personnel functions for the VNA are performed through the human resource department of MHS. Ken Cavanaugh, MHS' vice president of human resources, is in charge of the department. Cavanaugh directs Shirley Kirk, director of personnel, who in turn supervises the MMC personnel department. This department performs human resource and personnel functions for all of the MHS entities except for Lincoln and St. Vincent Hospitals

which are new acquisitions. It appears that the MMC personnel department establishes salary ranges and job descriptions for all MHS entities except for Lincoln and St. Vincent Hospitals. Also centralized through the MMC personnel department are such areas such as employment compensation, benefits, records, health, and employee relations.

The personnel department is involved in the interviewing and hiring of all employees for MHS's entities on the MHS campus. The personnel department also handles new employee orientation and general training programs for MHS. Barbara Sullivan frequently consults with and seeks advice from the personnel department on such subjects such as salary matters, performance appraisals, workers' compensation, MHS' employee policies, recruiting, and disciplinary issues. As indicated above, Sullivan's reliance on the department in this regard is not unique to the VNA. MHS's policy is that human resources services are to be provided to ''all subsidiary corporations through centralized personnel and education resources departments.''

Although the MMC personnel department takes care of recruitment, initial screening, and interviewing, the recruitment for VNA is specifically advertised as such. After a VNA applicant is screened or a current employee from another MHS entity applies for a transfer to VNA, Sullivan or another VNA manager interviews the applicant and the ultimate decision in regards to qualification and suitability to the job rests with the VNA hierarchy. VNA maintains its own payroll and maintains its own personnel policies and manual. While MHS seeks to have a level of uniformity in personnel matters among its subsidiaries, there are a number of distinctions due to history and to the different work environments at different facilities. For instance, VNA and MMC have distinct employee benefits and practices. The benefits distinctions between VNA and MMC include weekend pay differential, overtime calculations, minimum pay for call in holiday time, vacation carryover, family sick time, and appraisal systems. VNA has its own distinct job descriptions maintained on its own letterhead as does MMC.

VNA is specifically and separately licensed by the State of Illinois as a home health agency and as a hospice program provider. VNA has a separate checking account which it uses generally for the payment of VNA wages and expenses incurred through VNA work. However, the VNA accounting work and payroll functions are taken care of by MMC personnel. The VNA payroll is primarily taken care of by one payroll clerk who is located in the VNA facility. The payroll clerk is paid by MMC and is generally supervised by a MMC supervisor who is not on site. The VNA is charged back by MMC for the payroll and accounting services it performs. Income tax filings for VNA are prepared by MHS personnel but are signed by appropriate VNA officials. Audits of VNA accounts are supervised by Paul Smith who is the chief financial officer of MHS.

The record discloses a significant interchange of management and employees between the VNA and other MHS entities. Approximately 75 percent of VNA staff nurses transferred to the VNA from one of the MHS entities. Better than 40 percent of VNA's supervisors, including Executive Director Barbara Sullivan, formerly worked for other MHS entities. Also, a number of former VNA employees have transferred to other MHS entities.

There are also some types of ongoing interchange and functional contact between VNA and other MHS entities, particularly those involving MMC employees. There is sharp conflict between the parties in regards to some of the relationships between these groups of employees and the VNA and some aspects of these will be expanded below in regards to the composition of the unit found appropriate here. These employees have been labeled or categorized as ''float nurses,'' ''professional float staff,'' and ''shared staff.'' The VNA also uses per diem nurses or PNR nurses to supplement their staff from time to time. Generally, the per diem nurses provide the VNA with schedules indicating when they are available for work. They are not paid benefits and are not guaranteed work, but are only scheduled on an ''as needed'' basis. Because they are not paid benefits, they receive a slightly higher hourly rate. These nurses are not employed by MMC.

Most of the ''float'' nurses are utilized in the same fashion as the per diem nurses except they are regularly employed by MMC at its acute care hospital and ''moonlight'' at VNA. They are not regularly scheduled. Unlike per diem nurses, they receive benefits for their ''on call'' work for VNA. In this role, they are paid by VNA and are supervised by VNA supervisors. Additionally, there are approximately 13 ''monitor'' nurses who are sometimes described as ''float nurses.'' Monitor nurses work in the labor and delivery units of MMC. They are paid by MMC and are supervised by MMC supervisors. These MMC nurses read monitors that are hooked up to VNA home health patients who have high risk pregnancies and require fetal monitoring. VNA bills the patients for the service and pays MMC for the time spent by the MMC monitor nurses reading the monitors.

The ''Professional Float Staff'' are various non-nurse therapists and employees in certain positions the Petitioner maintains are not professional: the client specialist, physical therapist assistant, system analyst II, and application analyst I. Most all of the physical therapists and occupational therapists are MMC based and paid, with only six regularly assigned VNA work. These six are described as home health therapists and they are also paid by the MMC payroll. Executive Director Sullivan contracts with MMC's rehabilitation department and VNA pays for their services. Finally, VNA pays MMC for the use of two computer specialists who provide VNA with computer assistance and several dietitians who consult with the VNA on dietary matters.

Lastly, the Employer points to several groups of registered nurses at MMC that provide services for VNA and/or have contacts with VNA personnel. One group is the home health clinicians. These nurses work at MMC. They are involved in the discharging of patients and referring such patients for home health services by VNA if needed. They are supervised by MMC's director of social services and with the exception of Cindy Crouch work exclusively at MMC. VNA reimburses MMC for 40 percent of their pay. There are also seven clinical nurse specialists and a pain management nurse who do followup and maintain contact with former MMC patients. Although there is some conflicting evidence, it appears that these nurses are paid by MMC and that their work is a MMC project supervised by MMC supervisors.

There has not been any collective-bargaining history involving any of the facilities described and considered above. The parties stipulated that MMC is an acute care hospital as

defined in the Board's Health Care Rules, 29 CFR § 103.30(F)(1). The parties further stipulated that VNA, if found to be a single employer or a separate facility, would not be an acute care hospital as defined in the Board's Health Care Rules, 29 CFR § 103.30(F)(1).

Analysis—Scope of the Unit

Based on the above and the record as a whole, I find that MHS and VNA are a single or integrated employer in this proceeding. The record clearly indicates that MHS is an integrated health care enterprise or organization and that each of its entities are part of that integrated organization. MHS's ownership, financial control, centralized overall control of labor relations, and common overall management of all of its entities, including VNA and MMC, compels such a finding. *Radio Union v. Broadcast Service*, 380 U.S. 255, 256 (1965), and *Brattleboro Retreat*, 310 NLRB 615, 619 (1993). See also *Hydrolines, Inc*., 305 NLRB 416 (1991).

The single-employer status of MHS and VNA does not require a finding that MMC is also the same single employer or that MMC is a joint employer of VNA. The corporate structure and the managerial setting of MHS militates against such a finding. MHS' utilization of MMC's personnel department to perform human relations functions for VNA and other MHS entities does not indicate a coemployer or joint employer status of MMC to those entities when such functions are directly controlled by MHS and utilized for efficiency purposes by MHS. The other relationships established between VNA and MMC are similar. They are dictated and controlled by MHS for the same purposes and the services provided by MMC and received by VNA and are paid for by VNA in an arm's-length relationship. Under the circumstances, I view both MMC and the VNA as separate affiliates or subsidiary corporations of MHS as the other corporations affiliated with MHS appear to be. At any rate, the finding of single-employer status here does not determine the appropriate bargaining unit. Consideration of the scope of the unit examines employee community of interest. *Peter Kiewit Sons' Co*., 231 NLRB 76 (1977).

The Board has set out certain health care rules in a rulemaking proceeding regarding employee units in acute care hospitals. See 284 NLRB 1515 (1989). Absent extraordinary circumstances, an all registered nurses unit is appropriate in an acute care hospital. 284 NLRB 1580, 1596–1597 (1989). The Employer maintains that the VNA should be viewed as part of MMC or as a department of MMC, which is an acute care hospital, and as such, the Board's health care rules would compel the finding of a hospitalwide registered nurse unit and the petitioned unit of VNA registered nurses would be inappropriate. The INA, however, notes that VNA itself is not an acute care hospital andif VNA is found to be a single employer or facility, the Board's standards for determining community of interest in nonacute health care facilities established in *Park Manor Care Center*, 305 NLRB 872 (1991), should be controlling.

The Board has extended its ''single-location'' or ''single-facility'' presumption to the health care industry. *Manor Healthcare Corp*., 285 NLRB 224 (1987). See also *Samaritan Health Services*, 238 NLRB 629 (1978). The Board has consistently held that a single-facility unit is presumptively appropriate, even though a broader unit might also be appropriate, when that facility is separated and distinct from other facilities and is operated independently on a day-to-day basis. Contrary to the Employer here, I find that the VNA should be viewed as a single facility and that the presumption of a single-location or facility unit has not been rebutted in this matter. In reaching this finding, I first note VNA's geographical separation from MMC and other MHS entities on the MHS campus. It has its own identified building and parking facilities and is separated from MMC facilities by buildings and parking lots owned by the State of Illinois/or operated by Southern Illinois University Medical School. VNA's facility is separate and distinct from the MMC hospital complex and is held out to the public as such. The VNA has its own staff and patients and specialized services. A substantial number of VNA patients are not referred from MMC. It has its own supervisory staff which assigns and directs the work and controls personnel decisions. As indicated above, the use of the MMC's personnel department to perform various human resources functions under overall MHS control, does not merge the VNA with the MMC. Moreover, VNA has its own payroll, distinct employee benefits and policies which are administered on a day-to-day basis by its own executive director who reports to and is responsible to the VNA board of directors. See *Passavant Retirement & Health Center*, 313 NLRB 1216 (1994).

VNA's separate corporate structure and administrative independence are in great contrast to the departmental role of the home health office in *Sutter Roseville Medical Center*, Case 5–RC–14351 (formerly Case 20–RC–17144 (1996)), a case in which a request for review was very recently granted by the Board and brought to my attention by the Employer after briefs were filed here. I also note that the petition in that matter was seeking an overall registered nurses unit covering all of the Employer's facilities. Finally, in *Sutter*, the home health facility had previously been located inside of the hospital facility and it was to be relocated in the hospital therein when its new facility was completed. In contrast, VNA has always been located separately from the MMC hospital complex.

The Act does not require a unit be the *most* appropriate unit or the *only* appropriate unit; the Act requires only that unit be ''appropriate,'' that is, appropriate to insure to employees in each case ''the fullest freedom in exercising the rights guaranteed by this Act.'' *Morand Bros. Beverage Co*., 91 NLRB 409 (1950), enfd. 190 F.2d 576 (7th Cir. 1951). Accordingly, a petitioner is not required to seek representation in the most comprehensive grouping of employees. See *P. Ballantine & Sons*, 141 NLRB 1103 (1963).

In view of the above, I find that the VNA is a single facility and that the presumption that the scope of the unit can be properly confined to that facility has not been rebutted and the unit requested is not inappropriate in this regard.

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Other Composition Issues

In regards to the VNA registered nurses unit, there are several issues remaining to be resolved:

The Per Diem and Float Nurses—There are a small number of per diem nurses who perform services for the VNA on a volunteer basis when needed. Per diem nurses are covered under VNA personnel policies and VNA supervision just as regular VNA nurses. They do not enjoy fringe benefits but in exchange they receive a somewhat higher hourly

rate. Their schedules are irregular and they generally ''schedule'' their availability with the VNA.

The ''float'' nurses work under very similar conditions as the per diem nurses. These nurses work also on an ''as needed'' and an ''on call'' voluntary basis. However, the float nurses are regularly employed by MMC and they ''float'' or ''moonlight'' at VNA when there is work available. They are paid benefits and work under VNA supervision when doing VNA work. There are ''monitor'' nurses who work exclusively at MMC who have also been described as float nurses in the record here. I have designated them as monitor nurses and they will be treated separately below.

Contrary to the Employer, the Petitioner maintains that the per diem and float nurses are casual in nature and do not share a community of interest with the nurses within the unit found appropriate here. In deciding whether per diem or on call nurses should be included in a nurses unit, the board looks to the similarity of the work and the regularity and continuity of employment. See *S. S. Joachim Anne Residence*, 314 NLRB 1191, 1193 (1994). The record evidence indicates that the per diem and float nurses perform the same kinds of duties under the same conditions as VNA nurses and with the same VNA supervision. In regards to regularity, I find it appropriate to use the board's most widely used test in these matters—the *Davison-Paxon Co*. test. See 185 NLRB 21 (1970). Accordingly, I find that the Employer's per diem and float nurses are eligible if, and only if, they regularly average 4 hours or more per week during the quarter prior to the eligibility date. See *Sisters of Mercy Health Corp*., 278 NLRB 483 (1990).

The Shared Services Nurses—Contrary to the Petitioner, the Employer contends that certain nurses that it deemed shared service registered nurses should be included in any unit found appropriate here. Specifically, these employees include seven clinical nurse specialists (CNS), nine home health clinicians, and a pain management nurse.

The clinical nurse specialists are employed by MMC, paid by MMC, and are generally supervised by MMC supervisors. These nurses are involved in a MMC project called the community corroborative care program which maintains contact with and ''follows up'' former MMC patients. While there is some conflict on the record regarding whether these nurses have an occasion to be present at the VNA, it is apparent that such presence, if any, is limited with the exception of Allison Seiz. Seiz is engaged in pain management nursing and appears to do some field work in conjunction with the VNA hospice team.

The pain management nurse is Harlyne Callahan. Callahan is primarily assigned to the MMC pain clinic. She also does field work in conjunction with the VNA hospice team for approximately 10 percent of her time.

The home health clinicians are nurses that are employed by MMC as part of a recently instituted MMC program called the Home Health Connection. These nurses are involved in MMC's discharge planning and referring such patients to VNA if home health services are required. VNA pays MMC for 40 percent of their time for their services in this regard. With the exception of Cindy Crouch, who is VNA based, supervised, and is classified as VNA home health coordinator, these nurses are located in MMC's facilities, have no occasion to work at VNA, and are directly supervised by a MMC supervisor.